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ABSTRACT

This manual contains the first 2-hour session of a six-session sexuality guide designed for clinicians and facilitators working with chemically dependent women. The content of the manual is appropriate for inpatient programs, outpatient programs, and after-care groups. The manual begins with an introduction to women's sexuality in the 1980s and an explanation of how alcoholism affects the physical, emotional, social, and spiritual aspects of the chemically dependent woman. This introduction can serve as background information for the facilitator and as a reference source for the facilitator's own session introduction. A set of guidelines lists skills needed to facilitate women's groups and to facilitate a sexuality session. A session overview lists participant goals, session length, topic sequence and recommended times, trainer materials provided, and materials needed for the session. The detailed session outline consists of two parts: the Content Outline column which is intended as a guide to the actual sequenced topics and activities for the session and the Facilitator Activity column which provides a step-by-step guide to the session activities listed in the Content Outline column, helpful facilitating hints, and references to appropriate resources. A list of trainer materials is included. (NB)

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SEXUALITY
AND
THE CHEMICALLY DEPENDENT WOMAN

A Group Facilitator's Guide

Stephanie S. Covington, Ph.D.

This Guide was developed in collaboration with Pangea Training Systems, 3560 First Avenue, Ste. 7, San Diego, CA 92103.

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ABOUT THESE TRAINING MATERIALS

This manual contains the first segment of a six-session Sexuality guide designed for clinicians and facilitators working with chemically dependent women. *

The complete guide, to be published in early 1986, consists of training designs and materials that deal with sexuality in relation to the following topics:

- Language
- Physiology
- Body Image
- Relationships
- Intimacy

The content of this manual and of the complete guide is appropriate for use with both inpatient and outpatient programs as well as with after-care groups.

Although the format is designed for group facilitation, the materials will also prove useful to clinicians in private practice. Guidelines for adapting the format for use in individual treatment will be provided in the six-session edition.

* The complete Sexuality guide will include adaptation guidelines for clinicians and facilitators working with chemically dependent men.

WOMEN'S SEXUALITY IN THE '80s

An Introduction

We live in an addictive society obsessed with sex and alcohol. We are continually barraged by messages that in effect tell us to drink, eat, smoke, spend, and engage in any number of addictive behaviors.

Society also promotes a distorted view of female sexuality. Sexual literature, magazines, porn shops, sex aids and toys, pornographic movies, and sex in the media are but a few indicators of Americans' view of women and obsession with sexuality.

Many of the beliefs held about the relationship between alcohol and human sexuality are not only irrational, but--more importantly--are socially and interpersonally destructive. As women, we are literally bombarded through media exposure by very direct messages telling us that in order to be sensual, sexual, and attractive, we must drink alcohol. Society has conditioned us to believe we must drink in order to have fun. And for many alcoholics, having fun equates with sex.

The relationship between alcohol and human sexuality is pervasive and complex. It can be conceptualized as a spiralling relationship in which alcoholism is both cause and consequence of sexual conflict, identity confusion, and dysfunction.

Sexuality begins at conception--even <u>before</u> birth--with the determination of our gender, our sex. It develops throughout our childhood and adulthood. The development of our sexuality is affected both by our socialization--how society defines "maleness," and "femaleness"--and by our experiences within our families. Children are curious about their bodies and about sexuality. When parents act secretive, embarrassed, or ashamed in answering questions, children begin to feel that somehow they must have done something wrong by asking. They start to believe that sex must be something disgusting, something dirty, something to be kept secret.

Our socialization--our concept of what it means to be female--is very different from the way men are socialized. Men's socialization is about action, assertion, competition, risk. Women have been taught to be soft-spoken, polite, demure--in one word, passive. Through fairy tales, romantic novels, poems, songs, and soap operas we have been taught to expect to be "saved" by a handsome prince, football star, or dynastic hero, who will provide for us and with whom we will live happily ever after.

Men are socialized to perform sexually--to be the "great male lover," to "score," to make love to someone, rather than with someone. The focus is on numbers and performance: on sexual potency, on orgasms. Yet sexual activity is supposed to be about pleasure, not about performance. Somehow, the message has been lost.

Women's sexual socialization has been quite different and riddled with myths. Historically, women's sexuality has been defined by men. In the 1880s, women were told that they were not sexual beings, that sex was only for procreation. Now, in the 1980s, we are told that we should have multiple orgasms. Quite an evolutionary leap! Our ignorance is valued; women are supposed to know very little about sex. So we become guilt-ridden and feign lack of information about, and experience with, masturbation and sexual encounters.

Today women are taking more responsibility for their sexuality. In the past 10 to 15 years much information, written by women, has become available about women's sexuality and women's bodies. For the first time, women are beginning to take responsibility not only for their actions but also for sharing much-needed information.

The good news, then, is that more information is becoming available and being widely disseminated. However, we have much catching-up to do. To this day, there are women who believe in the existence of the vaginal orgasm--the idea that it is more normal, or a sign of greater maturity, for women to have orgasms vaginally rather than clitorally. This is a myth; 70% of women have orgasms by clitoral stimulation. Recent discovery

of the Grafenberg spot does show, however, that some women can have an orgasm by direct stimulation of this small area within the vagina.

What, then, is sexuality? It is an identification, an activity, a drive, an orientation, a biological-emotional process, an outlook, an expression of self. It is much more than sexual behavior. It is the totality of oneself. It is who we are in the world. And, according to noted sex therapist Helen Singer Kaplan, sexual health is "the somatic, emotional, social aspect of oneself integrated into one's identity and style of life." Note that we have no model for healthy female sexuality. The unspoken model for female sexuality is still grounded in the whore/virgin dichotomy--the stake or the pedestal. Once again, this is a male view of women we've inherited through the centuries from Western religion, the tradition of courtly love, and Rousseau's 19th century ideals. To this day, men will admit to their fantasy of having "a whore in bed and a lady at the breakfast table." Heaven forbid the roles should be reversed!

Because alcoholism affects the physical, emotional, social, and spiritual aspects of oneself, it affects every aspect of our sexuality. And, even though we are about to describe each of these aspects separately, in reality they cannot be separated--we must treat the whole human being, with respect and in totality.

Physical Factors. From a physiological standpoint, chemical abuse disrupts the body's delicate balance. In this author's own research, and in other studies, 85% of the women in the alcoholic sample had experienced some kind of sexual disfunction. The dysfunction did not differ in type, but rather in frequency, from dysfunction reported by nonalcoholic women. Types of dysfunction reported included lack of orgasm, lack of lubrication, lack of sexual arousal, painful intercourse, and muscular spasms.

There also seems to be a spiralling relationship between alcoholism and sexual dysfunction. The majority of women seemed to have experienced some dysfunction before their alcoholism began. So it appears that some women may start using alcohol to treat, or escape from, their difficulties. Over time, of course, alcohol only magnifies them.

Normally, in an erotic encounter all the senses are activated--seeing, hearing, touching, tasting, smelling. Nerves send messages to our bodies, and we experience sensations. Since alcohol is a depressant, and as such it is not selective within our system, its use deadens the arousal system, anesthesizing sensation and all the senses by affecting the neural pathways.

Emotional Factors. Repression is a highly developed defense mechanism among chemically dependent people. This is particularly true for alcoholic women, who experience shame, guilt, and low self-esteem. Such feelings are paralleled and magnified with respect to sexuality. The kinds of concerns women express in therapy are: inability to have orgasms, the fear and pain of loving another woman, fear of having sex sober, shame for prostituting themselves in order to get a drug of choice, and poor partner selection.

The guilt and shame women feel with regard to sexuality can be reduced to two categories: women either feel ashamed because they've had too much experience--too much sex, or they feel ashamed because they've had too little.

Social Factors. It is important to place women's issues into a larger social context. Social factors affect a women's sexuality and self-image from the moment of birth. The stereotypical role of what it means to be feminine is supported by every social institution in our society.

Yet the masculine and the feminine are in all of us; it is the androgynous person--the one who is able to use the feminine or the masculine characteristics when and as appropriate--who is actually the best adjusted

person in our society. And, according to new research by Sharon Wilsnack, the androgynous person is less likely to be alcoholic.

Intimacy in relationships is also an issue. Alcoholism can be considered an intimacy disorder. Alcoholism is a love affair with alcohol. When two people come together in a relationship, they bond. When one becomes an alcoholic, the bottle becomes the focus of attention, the new love object. The old bond breaks.

There's been much discussion about alcoholics being afraid of intimacy. With alcoholic women, it may also be fear of abuse. Probably the most destructive element to someone's sexuality is to have been abused--physicially, emotionally, or sexually. A history of abuse not only affects how someone functions physiologically, but also emotionally. Women who are abused often feel that they are to blame...and become cautious and guarded in relationships. Trust is a basic element in a relationship. Many people consider alcohol an aphrodisiac; actually, trust is the aphrodisiac, because trust allows surrender, which is part of the sexual experience.

Spirituality. Women's spirituality has often been connected to sexuality in a negative sense. We've been taught to suppress our sexuality in order to be more spiritual. Recovery for women means reclaiming our spirituality, our heritage. Ancient religions revered the Goddess. We come from a long line of healers, growers, and birthers. It is time for us to look at our sexuality and spirituality as originating from the same source--a life source in tune with the cyclical aspects of nature.

The '80s are an inspired time for spirituality. We hear about the imminent world transformation, and futurists speak of the evolutionary leap that is taking place in humankind's expanding consciousness. J.S. Bell's theorem and experiments have demonstrated the inter-connectedness of distant events, the oneness of apparently separate objects. The new physics tells us that matter is not static substance, but energy patterns and rates of vibration--that this is our essence. Energy, then, is the life force of our spirituality.

When two people, two patterns and rates of vibration, come together, their merged energy fields create a third, which sends out new information into the universe. The quality of that new information will depend on the quality of the energies that created it. We must begin to take responsibility for what we are creating in this world.

In Conclusion. In alcoholism treatment programs we often talk about the denial of families where there's alcoholism--how the disease is ignored and denied. That's exactly what has happened around sexuality in treatment programs. To quote Adrienne Rich, feminist writer and poet, "Lying is done with words and also with silence." This is particularly relevant for women: we have lied about our lives by silence for many years.

As treatment providers, our challenge is to break that silence--to be aware of our own attitudes, to give accurate information, to break myths, to provide groups for women where they can share their experiences and concerns. It's often said that sexuality is too "heavy" to be discussed in early treatment. This author disagrees. Sex therapy does need to wait six months to a year--but not the discussion of sexuality. Female sexuality can no longer be excluded and ignored. Since sexuality is the integration of all aspects of our lives, it is an issue that must be dealt with from the start in treatment programs designed for sobriety.

In this manual designed for women in the 1980s, we propose a repersonalization of sex, a personal bill of rights: the right to experience pleasure, the right to say no ... and yes, the right to act out of desire, not expectation.

FACILITATOR GUIDELINES

I. Facilitating Skills

FACILITATING WOMEN'S GROUPS

The design of the Sexuality session in this manual is based on these general group facilitating guidelines:

1. Eight to ten women, plus you--the facilitator--sit in a circle. Groups work best when they meet for a minimum of 1 1/2 hours. The outline in this manual is designed for a two-hour session.

2. As facilitator, your role is:

   - to guide the discussion towards relevant topics;
   - to keep the discussion focused on the topic selected;
   - to encourage every woman to take her turn.

   You may participate as a group member, sharing your own life experience, when therapeutically indicated--not out of your own need.

3. This kind of group is not for confrontation. Women are up against the wall everywhere in their daily lives. The group is one place where they can be secure, knowing that here they will not be challenged, argued with, or made to explain and justify thoughts, actions, or feelings.

4. Setting up a few group guidelines at the start helps to make the group safe for each member. Here is a list of major concerns:

   a. Time needs to be shared equally. Each member takes her turn speaking. Be flexible; if a woman has a great deal to say, she needs to be able to do so. However, she must also be aware of the need for other women to speak.

Therefore, whenever you open up discussion, try to give the group an idea of how much time is available to each person.

b. Confidentiality is a must. No personal information about any member should be discussed outside the group. Trust is essential--and there can be no trust if information about a group member is given to outsiders.

c. Each person deserves to be listened to attentively, without being interrupted. Each woman has an important experience to relate that must neither be judged nor challenged. Feelings are valid, no one can be told how to feel.

d. Ask women to speak about their own personal experiences--not in generalizations or abstractions. Sharing on a personal level, and using "I" statements, increases feelings of closeness among group members and everyone learns from others' personal experiences.

e. Ask women to strive for honesty. This goal need not be in conflict with privacy issues or with protecting the feelings of others.

f. Ask women to avoid side remarks to their neighbors. Ask that all remarks be shared with the group. Comments, questions, opinions are of interest to everyone present.

Write key words for each of these areas on newsprint in advance of the group meeting. Briefly discuss them at the start of the session. Seek comments from the group. If you can get their active involvement early on, the guidelines will be followed with very little intervention from you.

5. After everyone has spoken, there is a period when the group discusses the common elements in all the experiences. What are common themes, common problems? In helping the group to identify them, you can help them alleviate feelings of isolation. Encourage brainstorming to generate ideas on ways to bring about change--both social and personal.

Explore what keeps each person from making personal changes, and what kinds of support they believe they need. Explore what the group can do.

FACILITATING A SEXUALITY SESSION

Sexuality can be a sensitive and sometimes frightening area of discussion for groups: it is a topic often surrounded by mystification, embarrassment, and shame.

Helping people to open up, to break the denial and the silence that have surrounded sexuality is what this session is all about. Making it happen is a delicate process; it requires that the topic be approached gently, slowly, and gradually. As facilitator, your own preparation and sensitivity to issues and people's feelings will be invaluable.

No one will expect you to be an "expert" on sexuality. You don't need to have a ready answer to every question that comes up--although it helps if you are well informed. (Relevant information and a list of suggested readings are provided in the Trainer Materials section of this manual.) As facilitator your role is, literally, to be the group member who "makes things easier," who focuses the discussion so that, in coming up with their own answers, participants will develop a better understanding of themselves.

It <u>is</u> essential, however, for you to be in touch with your own feelings about sex and your own sexuality. It is also important that you feel comfortable participating in, and modeling, appropriate self-disclosure. Watch your preconceptions: we all have some. Have you monitored yours, lately? For example, when a married woman relates a sexual experience, do you assume it took place with her husband? Do you make heterosexual assumptions?

Be prepared to deal with "red flags" that come up fairly often in sessions on sexuality:

- Religious beliefs and attitudes: religious background may strongly color how a woman perceives sexual issues and how she feels about her own sexuality.

If someone refers to the Bible to question the way you approach a subject or guide the group, explain that your approach is based on academic information and research and on the therapeutic process.

- Sexual abuse and incest: it is not unusual for a group member to get in touch with experiences in this area. Therefore, it is important that there either be someone on staff trained to deal with both sexual abuse and incest, or that a referral source be readily available.

- Sexual orientation: group members may express questions or concerns in this area. Be prepared to refer them either to an openly gay woman on the staff, or to someone gay in the community who can provide both support and facilities. As facilitator, it is helpful for you to have some knowledge of lesbian lifestyles and the gay community (see Out from Under in Suggested Readings).

II. About this Manual

SESSION DESIGN

Two major design elements have been built into the session outline:

- a gradual, nonthreatening shift from impersonal to personal discussion of the topic;

- two components of successful sexuality sessions: the sharing of information and the sharing of group members' own experience.

It may help you to look at what a sexuality group session tries to accomplish by referring to the so-called P-LI-SS-IT model, a conceptual framework for individual sex counseling developed by Jack Annon (The Behavioral Treatment of Sexual Problems. Honolulu: Enabling Systems, Inc., 1974):

P (permission): giving permission to the client to do and not to do--to behave as she chooses;

LI (limited information): providing the client with specific information related to her problem;

SS (specific suggestion): directing the client's attempt to change her behavior through specific behavior modification techniques;

IT (intensive therapy): providing long-term treatment of dysfunction.

While all four components of the model are applicable to individual sex counseling, the first two (permission and information) need to be an integral part of alcoholism treatment programming, including groups.

SESSION FORMAT

The detailed session outline that follows is designed for a single two-hour session. It also includes a suggestion for modifying it to two two-hour sessions, time permitting.

Note that the outline is merely intended as a set of guidelines, not as a structure to be followed rigidly. With a sensitive topic like sexuality, it is best to build much flexibility into your session, so that you never have to cut short the natural flow of an important process in an effort to cover more content.

Building trust within the group is one of the facilitator's primary roles. An important technique you can use to accomplish this goal is to carefully guide the introduction of new material so that discussion shifts gradually from the impersonal to the personal.

USING THESE MATERIALS

SESSION OVERVIEW. This page provides the facilitator with a quick summary of essential information about the session.

INTRODUCTION ("Women's Sexuality in the '80s"). This essay serves a dual function:

- as background information for the facilitator;
- as reference source for the facilitator's own session introduction.

SESSION OUTLINE. The "Content Outline" column is intended as a guide to the actual sequenced topics and activites for a two-hour Sexuality session.

The material in this column is presented in the form of a script--that is, it provides the actual suggested wording that a facilitator might use in addressing group participants: the pronouns "you" and "we" address the group. Using the script <u>verbatim</u>, however, is not necessary.

The "Facilitator Activity" column provides a step-by-step guide to the session activities listed in the "Content Outline" column, helpful facilitating hints, and references to appropriate resources. Here the "you" addresses the facilitator.

SUGGESTED USES OF THE SESSION OUTLINE

1. <u>Facilitators.</u> We recommend that the outline be used by group facilitators in advance of the session and in preparation for it--not during the session itself.

2. <u>Clinicians</u>. When read as a sequenced strategy for dealing with sexuality issues, the "Content Outline" column can easily be adapted by clinicians working with individual clients.

TRAINER MATERIALS. All materials in this section are listed in the Session Overview. They include:

- materials that the facilitator may use as her own reference sources;
- suggested readings for both facilitator and group members;

- books recommended for purchase by the program, to be made available to group participants on a loan basis.

SESSION 1

SESSION OVERVIEW

PARTICIPANT GOALS

- to receive accurate information about female sexuality;
- to foster an atmosphere in which we feel comfortable, supported, and safe in discussing sexual issues, experiences, and feelings;
- to give ourselves permission to adopt a healthy personal model of sexual behavior.

SESSION LENGTH

Two hours

TOPIC SEQUENCE AND RECOMMENDED TIMES

Goals	5 min.
About this Session	5 min.
Why Sexuality ...	10 min.
Female Sexual Response	15 min.
Focus Questions	30-40 min.
Sexual Lifeline (Directions)	15 min.
Sexual Attitude Scale	20 min.
Close	10 min.

TRAINER MATERIALS PROVIDED

Sample Sexual Lifeline
Sample Sexual Lifeline with Alcoholism Overlay
Sexual Attitude Scale
Statistics on Sexual Dysfunction
Suggested Readings

MATERIALS NEEDED

Flip chart easel w/ pad, markers, masking tape
Newsprint, tag board
Colored markers, pencils, or crayons

FACILITATOR ACTIVITY	CONTENT OUTLINE
	GOALS
Direct group's attention to goals posted on flip chart page. Ask if anything needs to be changed or added. Follow through, then mount on wall to keep in view.	1. to receive accurate information about female sexuality; 2. to foster an atmosphere in which we feel comfortable, supported, and safe in discussing sexual issues, experiences, and feelings; 3. to give ourselves permission to adopt a healthy personal model of sexual behavior.
	ABOUT THIS SESSION
Acknowledge the sensitive nature of the topic for group discussion. As you talk, do your best to make the group feel supported and safe.	Sexuality is a sensitive topic for people. So, a session devoted to it can get "scary" at times: o because often this will be the first time that sex has been discussed openly; o because women have been socialized not to know and not to talk about sex; o because a comment triggers a painful memory; o because we may have used denial with sexuality as well as with our alcoholism; o because we're embarrassed, afraid, or ashamed to share a feeling or experience; o for any number of other, unique personal reasons. If such feelings come up for you, remember ... this is a safe place. Here our experiences are our reality, and will be valued.
Invite group to share any concerns they have	You only need to share as much as you're comfortable sharing.
Sexuality: Session 1	**1-2**

FACILITATOR ACTIVITY	CONTENT OUTLINE
Open the session with a lecturette similar to the "Women's Sexuality in the '80s" intro. Main points are highlighted here. Feel free to add your own. Allow about 10 min. for lecturette and group comments.	**WHY SEXUALITY IS AN IMPORTANT ISSUE FOR US** o as recovering women, we may be fearful of being sexual sober; o we may feel shame and guilt about our sexual activities while we were drinking; o our society gives us mixed messages about our sexuality, our femininity -- it's generally still the virgin/whore model; o traditionally, our sexuality has been defined for us by men; o basically, we have been told what others' expectations of us are, without being told what female sexuality is; o sexuality is the way we are in the world--it is the integration of every aspect of ourselves: physical, social, emotional, spiritual. Alcohol affects every part of our lives; o the media's message is that to be more attractive and sensual we have to drink alcohol; o for us to live our lives fully and sober, then, we need to look at how our sexuality influences our behavior, our outlook, our feelings; o there is a correlation between alcohol abuse and sexuality. Research on alcoholic women shows: - they have a higher frequency of sexual dysfunction than nonalcoholic women; - they are much more likely than other groups to have experienced some type of abuse--physical, sexual, or emotional--at an early age.
Sexuality: Session 1	**1-3**

FACILITATOR ACTIVITY	CONTENT OUTLINE
	In turn, this kind of background may cause sexual and intimacy problems.
Ask group to comment. Try to keep discussion from getting too personal at this early stage.	
	FEMALE SEXUAL RESPONSE
Say that alcohol abuse affects the normal sexual response cycle. Draw Fig. 1 on a flip chart. Discuss the points in the Content Outline.	o alcohol disrupts the physiological sexual response cycle (see Fig. 1);

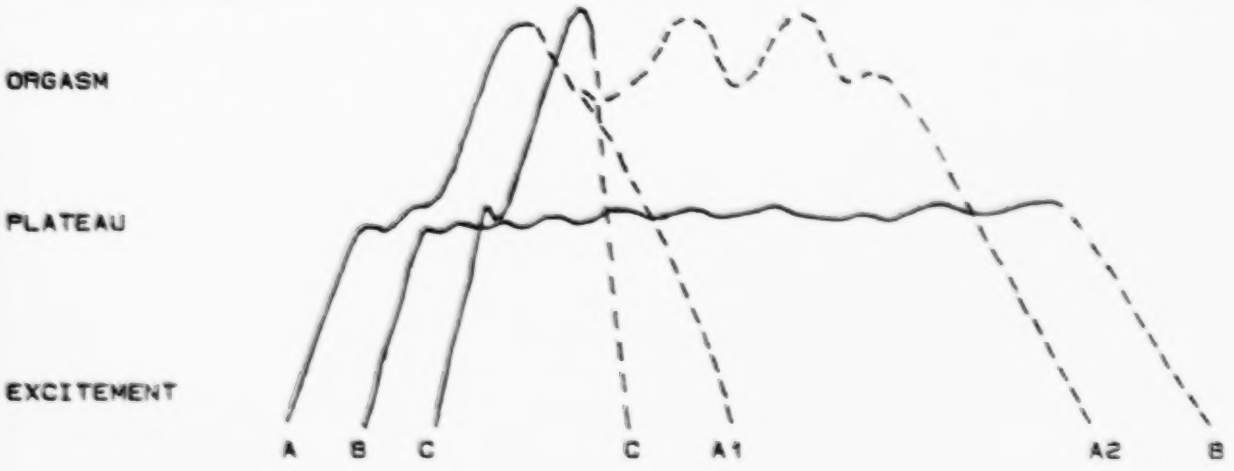

Fig. 1: Female Sexual Response Cycle

FACILITATOR ACTIVITY	CONTENT OUTLINE
	o during the excitement stage, there is vaginal lubrication, thickening and expansion of the vagina, erection of the clitoris, and tensing of muscles; o during the plateau stage, the clitoris withdraws--usually just before orgasm; there is body flush and tensing of muscles; o during orgasm, there are a variety of muscular contractions. Labels on Fig. 1 show: o A: typical response pattern in a sexual experience leading to orgasm: - excitement is followed by a plateau, then rises to orgasmic peak - resolution is gradual - A1: woman having one orgasm A2: woman having multiple orgasms o B: typical response pattern in a sexual experience that does not reach orgasm: - excitement rises to the plateau level and remains there - resolution is more gradual than after an orgasmic experience o C: typical response pattern in masturbation: - excitement rises more rapidly to orgasm, with a shorter plateau stage - orgasm is often more intense and quicker than in a sexual encounter - resolution occurs more quickly
Emphasize that the	Sexual dysfunction can occur at any stage of

FACILITATOR ACTIVITY	CONTENT OUTLINE
difference between alcoholic and non-alcoholic women is in the frequency, not in the types, of sexual dysfunctions experienced.	the response cycle.
	Desire Phase Disorders
Discuss points listed, then solicit group's comments.	Desire phase disorders include: o aversion o lack of interest o differences in desired frequency of sex Alcoholic relationships experience many problems in this area.
	Excitement Phase Disorders
Emphasize the difference in concern when women experience lack of lubrication versus when men experience erectile dysfunction!	Lack of lubrication is the primary excitement phase disorder. Physiologically, it corresponds to erectile dysfunction in men.
	Orgasmic Phase Disorders
Point out that this is the most common type of problem of sexual dysfunction. Note that the term "frigid" was used in the past and is no longer used.	The greatest variety of dysfunction occurs during this stage: o preorgasmia - inability to reach orgasm - women who have not been orgasmic are referred to as "preorgasmic"

FACILITATOR ACTIVITY	CONTENT OUTLINE
While discussing the various dysfunctions, also refer to the "Statistics on Sexual Dysfunction Reported by Alcoholic Women" in the Trainer Materials. This data shows the prevalence of sexual dysfunction before, during, and after alcoholism.	o situational anorgasmia - the ability to have an orgasm in one sexual situation (masturbation, for example) and not in another (with a partner, for example) o vaginismus - the involuntary contraction of vaginal muscles; causes are generally psychological o dyspareunia - any type of painful intercourse - a problem that occurs infrequently
	FOCUS QUESTIONS
Lead into the focus questions by emphasizing that a main purpose in talking about the female response cycle was to begin the process of opening up--of starting to move out of secrecy and denial. Many of our problems with sexuality have stemmed from lack of information. It is time to break silence. Tell group that while the focus of this session is not to treat specific sexual problems, areas of difficulty may be discussed either with	1. What do you think sex education means? Where did you get <u>your</u> sex education?

FACILITATOR ACTIVITY	CONTENT OUTLINE
you after the session or with individual counselors. Point out that specific treatment methods are available for each type of problem. Many people have been treated successfully. Also, some spontaneous remissions can occur in sobriety. After each question, allow plenty of time for the group to process it. Be flexible and use your own discretion. The questions are intended as guidelines. Take your cue from the natural flow of the group's interest and pace.	
For q. 2, ask group to consider influence of advertising and men.	2. Did you, or do you, think of yourself as sexually desirable? Where did you get this self-concept? Are you satisfied with it? 3. What was your experience with your first menstruation?
Encourage discussion and sharing of experiences with orgasm. Refer to the "Women's Sexuality" intro for comments on clitoral and vaginal orgasms.	4. When did you first learn about orgasm? What is meant by a clitoral and a vaginal orgasm? How important is this information to you? What difference do you suppose it would make if all women had this information?

FACILITATOR ACTIVITY	CONTENT OUTLINE
As facilitator, you also need to be familiar with Masters and Johnson's and Ladas and Whipple's conclusions on this topic. See Suggested Readings.	
Encourage discussion and sharing of experiences.	5. When did you first learn about masturbation?
Comment that the human need for intimacy is more complex and demanding than the need for sexual satisfaction.	6. Since physical release and pleasure can be obtained through masturbation, what else do you seek in shared sexual activity?
This is the most important of the focus questions. Ask it at the end, so it can lead into the lifeline exercise that follows.	7. How do you think alcoholism has affected your sexuality?
	SEXUAL/ALCOHOL ABUSE LIFELINE
NOTE: If "Sexuality" is a single two-hour session, tell group they will learn how to do the lifeline exercise in the session. The lifeline itself will be an assignment to be completed on their own time, to be processed later with their individual counselor.	
Sexuality: Session 1	1-9

FACILITATOR ACTIVITY	CONTENT OUTLINE
If you are working with a two two-hour "Sexuality" session format, the homework assignment can be shared and processed during the second session.	
As you introduce the sexual lifeline exercise, show a sample sexual lifeline. See Fig. 2. One is also enclosed in the Trainer Materials. You may also choose to use your own sexual lifeline, preparend in advance, as an example.	1. Plot a line that represents your past sexual life and experiences - draw a straight horizontal line across a page; this is the baseline - at one end of the line, place a plus sign above it and a minus sign below
To save time, it may be helpful for you to hand out newsprint or tagboard with the horizontal and vertical lines and years already premarked.	- just below the line, place numbers representing various ages, at two or three years' intervals. Start at any age--perhaps with your earliest sexual memory. What are your earliest recollections of touching yourself? Of being touched?
From this point on, the directions in the Content Outline column refer to the assignment the women are to complete on their own time.	- draw your sexual lifeline across the baseline. Positive, satisfactory experiences will be above the line; negative, unsatisfactory experiences will be below it - mark peaks and valleys with identifying labels and dates
If you are a recovering woman, and you have used your own sexual lifeline as example, add your alcohol abuse overlay.	2. Plot a line that represents your drinking history; - overlay the alcohol abuse lifeline over the sexual lifeline by using a different color marker
Sexuality: Session 1	1-10

FACILITATOR ACTIVITY	CONTENT OUTLINE
You may also use the sample lifeline with overlay enclosed in the Trainer Materials. Remember: discussion of the lifeline assignment is reserved either for a second session or for processing with individual counselors.	

Fig. 2: Sample Lifeline

Lead into Sexual Attitude Scale by pointing out that our attitudes influence our behavior. Ideas about sex affect how we act and how we feel about ourselves. The first step towards change is self-awareness.	SEXUAL ATTITUDE SCALE

FACILITATOR ACTIVITY	CONTENT OUTLINE
Hand out the Sexual Attitude Scale. A copy is included in the Trainer Materials. Before you give the directions, reassure the women that they will not have to share their attitudes with the group.	**Directions** For each statement on the Scale, circle the number where you feel you are now, and an "x" on the line where you would like to be. When everyone has completed the Scale, find a partner to work with. It is not necessary for you to disclose the details of your Scale. However, do share: o what areas of your life you would like to change; o what steps you would need to take to make those changes. **CLOSE**
Tell group that in closing you would like them to join in a visualization. If you have not lead a guided imagery exercise before, listen to a prerecorded one or practice with a friend before leading this one.	
Sexuality: Session 1	**1-12**

FACILITATOR ACTIVITY	CONTENT OUTLINE
Ask the women to close their eyes and join hands.	**Visualization**
Read very slowly--allowing time for women to visualize and experience.	See yourself as you are today--a sober, recovering woman... ... see yourself in a place that is special for you... ... perhaps a beautiful meadow... ... or a peaceful valley. Note that you are walking on a path... ...the path of recovery and sobriety. As you continue on that path... ... note that you are becoming more and more alive... ... more and more in touch with your sexual self... ... you are becoming the sensual woman that you want to be.
After a few moments of silence, ask the women to open their eyes. End the session with a closing statement along the lines of the model shown here.	**Closing Statement** Let's congratulate ourselves for "breaking the silence" that surrounds female sexuality. A sign of our growth is being able as women to open up and share the personal aspects of our lives. This is one of the ways to break isolation--for us to be able to experience our commonality, the common threads in our lives.

Trainer Materials

Statistics on Sexual Dysfunction

Reported by Alcoholic and Nonalcoholic Women

Sexual Dysfunction	Alc. (N=35)	Nonalc. (N=35)
Reports of dysfunction	85%	59%

Alcoholic women reporting dysfunction:

Before	During Alcoholism	After
79%	85%	74%

Types of Dysfunction	Alc.	Nonalc.
Lack of sexual interest	54%	44%
Lack of sexual arousal or pleasure	61%	30%
Painful intercourse	24%	9%
Muscular spasms	6%	--
Lack of orgasm	64%	27%
Lack of lubrication	46%	24%

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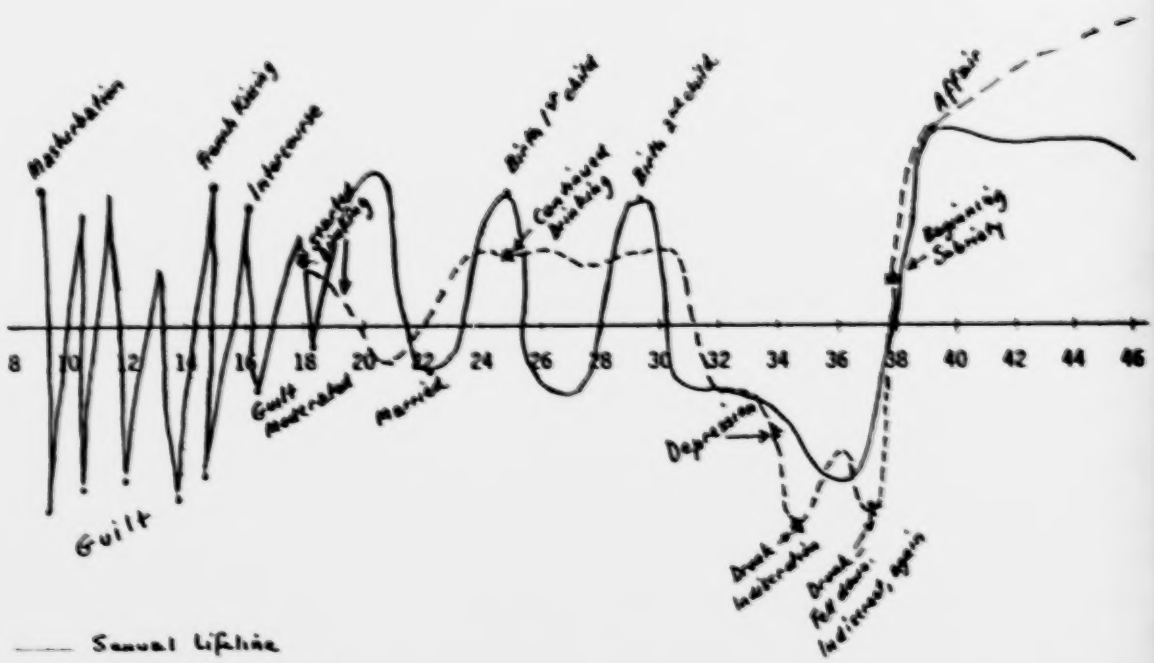
SEXUAL LIFELINE WITH ALCOHOL ABUSE OVERLAY



Hand-out

SEXUAL ATTITUDE AND BEHAVIOR SCALE

Directions: Circle the number on the scale that shows where you are now; draw an arrow to where you would like to be.

Unable to communicate verbally with partner my sexual likes and dislikes. — Able to communicate verbally with a partner my sexual likes and dislikes.

1 2 3 4 5 6 7 8 9 10

Little knowledge of what excites and turns me on sexually. — A great deal of knowledge of what turns me on sexually.

1 2 3 4 5 6 7 8 9 10

Uncomfortable touching or looking at my body nude. — Very comfortable touching and looking at my body nude.

1 2 3 4 5 6 7 8 9 10

Masturbation is a sin, wrong, or I feel guilty about doing it. — Masturbation is healthy and a way to care for myself.

1 2 3 4 5 6 7 8 9 10

Sexual fulfillment will come to me if I am with the right partner. — Sexual fulfillment is something I must work on and actively seek by telling my partner what I like.

1 2 3 4 5 6 7 8 9 10

I get few of my sexual needs taken care of. — I get most of my sexual needs taken care of.

1 2 3 4 5 6 7 8 9 10

I feel my body is not very beautiful. — I feel my body is very beautiful.

1 2 3 4 5 6 7 8 9 10

Others find my body very unattractive. — Others find my body very attractive.

1 2 3 4 5 6 7 8 9 10

I must be in love to really enjoy sex. — I can enjoy sex depending on my decision and not on whether I am in love.

1 2 3 4 5 6 7 8 9 10

I usually find myself giving to others sexually and doing what pleases them. — I find I want to give and get pleasure equally.

1 2 3 4 5 6 7 8 9 10

I fake orgasms often. — I never fake orgasms.

1 2 3 4 5 6 7 8 9 10

My sexual activity tends to always be the same. — I like to engage in a variety of sexual behavior and activities.

1 2 3 4 5 6 7 8 9 10

I never masturbate. — I often masturbate.

1 2 3 4 5 6 7 8 9 10

I seldom or never have orgasms. — I usually have orgasms.

1 2 3 4 5 6 7 8 9 10

SUGGESTED READINGS

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* Indicates basic materials for treatment programs/clinicians' libraries.

ABOUT THE AUTHOR

Dr. Stephanie Covington is an internationally known speaker and trainer specializing in programs on chemical dependency for professionals in health care, industry, and the general public. She is a director of Pangea Training Systems.

Educated at Columbia University and Union Graduate School, Dr. Covington has served on the faculties of the University of Southern California, San Diego State University, and the California School of Professional Psychology. She has conducted seminars for health professionals, business groups, and community organizations.

Dr. Covington's approach to the sensitive issues of women and addiction has given participants in her many workshops an opportunity to learn new skills in dealing with personal and societal changes in the 1980s.

Currently Chair of the Women's Committee of the International Council on Alcoholism and Addiction, Dr. Covington is listed in Who's Who in California. In 1983 she was cited by the California Women's Commission on Alcoholism (San Diego Chapter) for her significant contribution to alcoholic women.

Dr. Covington maintains a psychotherapy practice in La Jolla, California.